TALL TREE ADMINISTRATORS

Washington County Employee Benefit Enrollment Form

Section 1 - Employee Information

Employee Last Name | First Name | M.I. | Sex

Birth Date (MM/DD/YY) | Social Security Number

Employee Address | Home Telephone Number

City | State | ZIP | Work Telephone Number

Hire Date | Eligibility Effective Date | Additional Comments of Explanations

Section 2 - Medical Plan Coverage Elections or Waiver of Coverage

Coverage Elected

	Medical/Vision	Dental
Employee	☐	☐
2 Party	☐	☐
Family	☐	☐

Coverage Declined

Medical/Vision ☐ Dental ☐

I have decided not to apply for coverage at this time for myself or my dependents (if any). (Note: See Section III. ENROLLMENT AND COVERAGE in the Plan booklet for information on how you may be able to enroll in the future. Employee must sign here if declining coverage.

X

Section 3 - Legal Spouse Information

Spouse's Last Name | First Name | M.I. | Sex

Birth Date (MM/DD/YY) | Social Security Number

Is there other Insurance

☐ Yes Is spouse covered by another health plan?

☐ No If yes, you must complete the "Other Insurance" section on back.

Section 4 - Legal Dependent Children Information

Relationship Code Key:
S: Spouse B: Biological Child SC: Step Child A: Adopted O: Other

Dependent's Last Name	First Name	M.I.	Sex	Relationship	Birth	Social Security Number

If Enrolling dependents, you must answer this question: Are any of the dependent children you are enrolling covered under another health plan? If yes, you must complete "Other Insurance" section on back.

Yes ☐ ☐ No

Please note that married dependents are <u>NOT</u> eligible for dental coverage. Please indicate if married dependent is only eligible for Med/Vis coverage.

Section 5 - Employee Signature

Please read carefully before signing: I certify that the information on this enrollment form is true and complete. I hereby apply for this coverage. I authorize my employer to make the necessary payroll deductions. I authorized any health care provider to release all information pertaining to care provided to me or my dependents. A photocopy of this authorization shall be valid as the original.

X

I understand I may not drop my coverage unless there is a Qualifying Event or the Plan has an open enrollment period.

Section 6 - Other Insurance Information

If you, or any member of your family are covered by another health plan, you must complete this section. Please consult the other plan's ID care in order to give the following specific information we can use to coordinate your benefits with other health coverage you may have.

Other Health Plan

Name of Health Plan

Group or policy # | Telephone number of Health Plan | Date coverage began

Names of all individuals covered under this plan and any additional explanations or information about this coverage

Section 7 - Previous Coverage Information

If you or any member of your family have had prior coverage, please attach a copy of your Certificate of Creditable Coverage detailing who the prior coverage was with. In addition, list the date coverage began, the date it ended, and which members of your family, if any, were covered under the prior carrier. Please indicate below your prior carrier's information. If you do not submit prior coverage information, pre-existing condition limitations may apply.

Name and Number of Prior Health Carrier: | Prior Coverage State Date | Prior Coverage End Date

Sign here if you've had no prior coverage, or if there's been a break in coverage greater than 62 days

Section 8 - Electronic Data Information

For your security and privacy reasons as well as timeliness, you will be able to access your EOBs online when a claims has been processed for you or your family members. This gives you the opportunity to view on our secure web-site, all information regarding your claims and eligibility including your Explanation of Benefits (EOB). You will also be able to print your EOBs from the website.

Office Use Only

☐ Regular Enrollment: Completed within 31 days of eligible date — Effective date of Coverage

☐ Late Enrollment: NOT completed within 31 days of eligible date

X _____

Employer Group Representative **Date Signed**